

# Personal Information Worksheet

## To Help Compare Medicare-Approved Drug Discount Cards

There are several different Medicare-approved drug discount cards available in Nebraska, and any person who has Medicare and does not have prescription drug coverage through Medicaid is eligible to enroll and use a card to get a discount on his or her prescription medications. It is important to compare the cards, because each card may differ on the drugs discounted, the dollar amount discounted, and the choice of pharmacies that may be used. This worksheet will help you assemble the information you will need to compare the cards available. This information will also help you learn if you may be eligible for a \$600 credit that Medicare is providing each year to beneficiaries whose annual income (in 2005) is below \$12,919 (single person) or \$17,320 (couple). Complete this worksheet, then use the contact information provided to find out which card might be best for you. If you are married, you will need to fill out a separate worksheet for your spouse.

### **STEP ONE: ANSWER ALL OF THE FOLLOWING QUESTIONS**

- (1) **Do you have Medicare?** Circle: YES or NO
- (2) **Are you receiving any of the following:** (check the box if you have that coverage)
- ☐ Outpatient prescription drug benefits through Medicaid
  - ☐ TRICARE (military health insurance) that includes prescription drug coverage
  - ☐ FEHBP (health insurance for federal employees or retirees)
  - ☐ Other health insurance coverage that includes prescription drugs, such as an employer or retiree health plan?
  - ☐ None of the above
- (3) **What is your zip code and county?** Zip Code: \_\_\_\_\_ County: \_\_\_\_\_
- (4) **Are you using an American Indian Health pharmacy?** Circle: YES or NO
- (5) **Do you live in a Long-Term Care facility and receive your prescriptions from a pharmacy that serves that facility?** Circle: YES or NO
- (6) **Are you enrolled in a Medicare Advantage plan? (i.e. managed care plan, or Medicare+Choice)**  
(This could be a Medicare HMO, Medicare PPO, Medicare POS or Medicare PFFS plan. This does not include standardized Medicare Supplement policies.) Circle: YES or NO
- (7) **Are you married?** Circle: YES or NO

Note: Questions 8 & 9 are optional, but filling them out will help you get the best information about what assistance is available for you. The information you provide is confidential, and no one is recording or saving the information you provide.

- (8) **What is your monthly income?** \$ \_\_\_\_\_ per month  
(Income includes money that you [or if you are married, you and your spouse combined] receive through retirement benefits from Social Security, Railroad, the Federal government, or other sources, and benefits you receive for a disability or as a Veteran, plus any other sources of the type that you would report for tax purposes. Income should include the Medicare Part B premium.)
- (9) **What is the amount of your financial resources?** \$ \_\_\_\_\_  
(Including bank accounts, stocks, bonds, but excluding your house, one car, burial plots, furniture, some life insurance.)

*(continue to the next page)*

(10) **List the prescription drugs you are currently taking.** (Please print.)

This information can be found on your prescription bottle. If you need assistance, ask your pharmacist for the following information. The **correct spelling** of the drug name, the **dosage** and the **frequency** you take each drug, and the **price** you are paying now are all necessary to compare the discount cards.

-For oral drugs, list the dosage and type (tablet, caplet, etc)

-For non-oral drugs (eyedrops, creams, ointments, patches, insulin, inhalers, etc), list the amount in each bottle/tube/inhaler, and the number of bottles/tubes/inhalers used each month

Note: If you are taking several medications, you may want to list only the most expensive prescriptions, or you may want to list only the prescriptions you do not already receive a discount on through a pharmaceutical assistance program - a Together Rx or Orange Card, for example.

<b>Drug Name:</b>	<b>Dosage:</b>	<b>Taken how often:</b>	<b>Price per month:</b>
<i>Examples: Lipitor</i>	<i>10mg tablets</i>	<i>2 times per day</i>	<i>\$130.00</i>
<i>Albuterol</i>	<i>17 grams/inhaler</i>	<i>1 inhaler per month</i>	<i>\$14.00</i>
<i>Xalatan .005%</i>	<i>2.5 mL/bottle</i>	<i>1 bottle per month</i>	<i>\$51.00</i>

(if you have additional prescriptions, list them in a similar format on another sheet)

(11) The website will automatically search for a pharmacy located in the zip code you listed in Question #3. **If you know you are looking for pharmacies located in a different zip code, please enter that Zip Code here:** \_\_\_\_\_

(12) **Please list the names of the pharmacies you prefer to use.** (List two or three pharmacies.)

(13) **Retail pharmacy pricing will automatically be displayed, along with a mail order alternative. Are you interested in using mail order?** Circle: YES or NO

(14) **Contact Information:**

Name: \_\_\_\_\_ Phone number: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## **STEP TWO: USE THE INFORMATION TO COMPARE CARDS**

After you have completed Questions 1-14, use the information to compare the Medicare-approved drug discount cards available in Nebraska by doing one of the following:

### **Option 1:**

Go on the internet and visit [WWW.MEDICARE.GOV](http://WWW.MEDICARE.GOV). (If you do not have internet access, most local libraries and some senior centers will have a computer you can use. Consider asking one of your family members, as well.) Select the “Find a Medicare-Approved Drug Discount Card” link, and answer the questions using the information you have provided on this form. The website will use the information you provide on your income, prescription drugs, and pharmacy preference to compare the cards available to you. (It is also a good idea to call your pharmacy and confirm that it will accept the card you chose.) If you are eligible for the \$600 credit, you can automatically enroll online. If you are only eligible to get a drug card, it will give you the contact information to enroll in the card you choose.

HINT: On the “Summary Results” page, you can also click on the “Pharmaceutical Assistance Programs” link to obtain more information about other pharmaceutical discount programs available through the drug manufacturers. These programs can help provide prescriptions free or for low-cost to beneficiaries who meet income and/or asset guidelines, and some income limits for these programs can be very generous.

OR

### **Option 2:**

Call 1-800-MEDICARE (1-800-633-4227) and ask about the Medicare-approved drug discount cards. Medicare has hired 1,800 additional Customer Service Representatives to help assist a person in choosing which card is best for them. The customer service representative will ask you several questions, and will enter the information into the [www.medicare.gov](http://www.medicare.gov) website. Use the information you have assembled on this worksheet to help answer the questions. The customer service rep can possibly enroll you over the phone, or can provide you with contact information for the drug card that will give you the most savings. They can also send you a booklet of the results.

OR

### **Option 3:**

If you are eligible for the \$600 credit and a SHIIP Counselor is assisting you with the enrollment process, you will need to give them additional information in order for them to help you enroll. If you are working with a SHIIP counselor and are eligible for the \$600 credit (income in 2005 less than \$12,919 if you are single, or \$17,320 if you are married, and no other comprehensive drug coverage) please complete Page 4 of this Worksheet.

**Option 3, continued: Additional information needed for enrollment in card with \$600 credit.**

**Gender:** Circle: MALE or FEMALE

**Date of Birth:** Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Medicare number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (the last blank should be a letter)

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Spouse's Social Security number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(if married)

**Does the state help pay your Medicare Part A or Part B premiums?** Circle: YES or NO

**Have you recently (within the last 2 years) retired or been widowed or divorced?** Circle: YES or NO

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Once you have completed the above questions, if you would like a SHIIP Counselor to enroll you in a Medicare-Approved Drug Discount Card, please read and sign below.

**Release of Information**

By signing below, you allow the Nebraska Senior Health Insurance Information Program (SHIIP) to use this information to enroll you in a Medicare-Approved Drug Discount Card. You understand that you will be enrolled in the Card that will save you the most money on the prescriptions you listed on this form under Question #10, and can be used at a pharmacy you listed under Question #11. It is understood that the SHIIP Counselors are using information provided to them by CMS via the [www.medicare.gov](http://www.medicare.gov) website or 1-800-Medicare. (You will receive a confirmation number and information about the Medicare-Approved Drug Discount Card in which you are enrolled.)

\_\_\_\_\_  
Name Date

By allowing for enrollment in this company's Medicare-approved drug discount card, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the company of the Medicare-approved drug discount card. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B). I also allow the State Medicaid Program, Social Security Administration, and Internal Revenue Service, or any other agency with relevant information about me to give CMS or CMS's agents the information needed to determine if I am eligible for the Medicare-approved prescription drug card and, if applying, for a credit of up to \$600 toward prescription drugs.

By signing below, you (or your representative) will certify that you have read and understand the information contained on this enrollment form. Federal law provides for fine or imprisonment, or both, for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this electronic form is correct and complete to the best of my knowledge.

\_\_\_\_\_  
Name Date

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